MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

MARYLAND Department of Health

Demographics			
Student Name:	DOB:	Grade:	Diagnosis:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

Insulin Orders

Insulin Dosing:

□ Carbohydrate coverage □ Correction dose only □ Correction dose plus CHO coverage □ Fixed dose □ Fixed insulin dose with dosing scale □ See attached dosing scale

Insulin(s):

□ **Rapid Acting:** □ Apidra □ Humalog □ Novolog □ Any of the **rapid acting** insulins may be substituted for the others

□ **Long Acting** (if given at school): _____ Give _____ unit(s) at _____ (time)

Insulin Delivery: □ Pen □ Syringe □ Pump (make/model):

Carbohydrate (CHO) Coverage per meal:

□ _____unit(s) of insulin SQ per ____ grams of CHO at breakfast □ _____ unit(s) of insulin SQ per _____ grams of CHO at lunch

Carbohydrate Dose Adjustment Prior To Strenuous Exercise:

□ Use exercise/PE CHO ratio of ____ unit(s) of insulin per ____ grams of CHO at breakfast

□ Use exercise/PE CHO ratio of ____ unit(s) of insulin per ____ grams of CHO at lunch

Correction Dose:

□ Give ____ unit(s) of insulin SQ for every ____ mg/dl greater than target BG of _____ mg/dl

□ If pre-meal BG less than ____ mg/dl, subtract ____ unit(s) of insulin dose

□ **Fixed Dose Insulin:** ____ unit(s) of insulin SQ given before school meals

□ **Split Insulin Dose**:

Give ____ unit(s) or ____% of meal insulin dose SQ before meal and ____ unit(s) or ____% of meal insulin dose SQ after meal

Snack Insulin Coverage:

□ ____ unit(s) of insulin SQ per ____ grams of CHO in snack □ _____unit(s) of insulin SQ for snack greater than ____ grams of CHO

Ketone Coverage

For ketones <u>trace to small</u> (urine)/<_____ mmol/L (blood)	**For ketones <u>moderate to large</u> (urine)/>_____ mmol/L (blood)**
□ Correction dose plus ____ unit(s) of insulin	□ Correction dose plus ____ unit(s) of insulin
□ ____ unit(s) of insulin	□ ____ unit(s) of insulin

Insulin Dose Administration Principles

Insulin should be given:

- □ Before meals □ Before snacks □ Other times (please specify):
- □ For hyperglycemia if BG > _____ mg/dl and _____ hours since last dose/bolus
- □ If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack
- □ If parent requests, insulin should be given no more than _____ minutes after start of meal/snack

□ Use pump or bolus device calculations per programmed settings, once settings have been verified

□ Parent has permission to increase/decrease insulin correction dose by +/- ___ unit(s) or by ratio ____ unit(s) to _____ mg/dl

□ Parent has permission to increase/decrease CHO coverage by +/- ___ unit(s) of insulin or by ratio of ___ unit(s) to ____ grams of CHO

Independent Insulin Administration Skills & Supervision Needs*

*Skills to be verified by school nurse

□ Insulin dose calculations	□ Carbohydrate counting	□ Measuring insulin	□ Insulin administration
□ Independent □ With Supervision	□ Independent □ With Supervision	□ Independent □ With Supervision	□ Independent □ With Supervision

Other Diabetes Medication

Name of Medication	Time	Dosage	Route	Possible Side Effects

Authorizations

HEALTH CARE PROVIDER AUTHORIZATION		PARENT/GUARDIAN AUTHORIZATION	
I authorize the administration of the medications and student diabetes self-management as ordered above.		By signing below, I authorize: • The designated school personnel to administer the medication and treatment orders as prescribed above. By signing below, I agree to: • Provide the necessary diabetes management supplies and equipment; and • Notify the nurse of any changes in my child's care or condition.	
Provider Name (PRINT):			
Phone:	**Fax:**		
Provider Signature:	**Date:**	**Parent Signature:**	**Date:**

Acknowledged and received by: **School Nurse:** **Date:**

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Student Name:	**DOB:**	**Grade:**

Blood Glucose Monitoring* *Self-management skills to be verified by school nurse

Blood Glucose (BG) Monitoring:

□ Before meals □ Before PE/Activity □ After PE/Activity □ Prior to dismissal □ Additional monitoring per parent request

□ For symptoms of hypo/hyperglycemia & anytime the student does not feel well □ **Student may independently check BG***

Continuous Glucose Monitoring

□ Uses CGM Make/Model:

□ Other: □ Other:

Alarms set for: Low _____ mg/dl High _____ mg/dl □ If sensor falls out at school, notify parent

Hypoglycemia Management* *Self-management skills to be verified by school nurse

Mild or Moderate Hypoglycemia (BG _____mg/dl to _____mg/dl):

□ **Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. If glucose gel is given, place student in recovery position.**

□ Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl

□ Student should consume a meal or snack within _____ minutes after treating hypoglycemia

□ Other:

Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

- If BG still low, re-treat with 15 gram quick-acting CHO as stated above
- If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
- If CGM in use and BG 70 and arrow going up, no need to recheck

Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: □ Yes □ No

Severe Hypoglycemia (BG < _____mg/dl):

If symptoms worsen despite treatment/retreatment _____times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give:

□ **GLUCAGON** injection: □ 1 mg □ 0.5 mg IM or SQ

- Place student in the recovery position
- Suspend pump, if applicable, and restart pump at BG > _____ mg/dl
- Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

□ Use glucose gel inside cheek, even if unconscious, seizing if glucagon not available or there is no response to glucagon administration. **If glucose gel is given, place student in recovery position.**

Hyperglycemia Management* *Self-management skills to be verified by school nurse

If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

- If urine ketones are **trace to small** or blood ketones _____mmol/L:
  - Give _____ ounces of sugar-free fluid or water per hour
  - Give insulin as listed in Insulin Orders
- If urine ketones are **moderate to large** or blood ketones greater than _____ mmol/L
  - Give _____ ounces of sugar-free fluid or water
  - Give insulin as listed in Insulin Orders
- **If large ketones, vomiting or other signs of ketoacidosis, call 911**. Notify parent/guardian
- Recheck BG and ketones _____ hours after administering insulin
- Contact Parent/Guardian for: □ BG > _____mg/dl □ Ketones _____ mmol/L

Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse: □ Yes □ No

Snacks

Snacks needed:

□ Before physical education/physical activity/sports longer than _____ mins □ Per parent/guardian □ Per student

□ Limit snack to _____ grams of CHO □ Delay snack if BG > _____ mg/dl □ No snack coverage □ Other:

Provider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**

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Student Name:	**DOB:**	**Grade:**

Physical Education, Physical Activity, and Sports

□ Avoid physical education, physical activity, and sports if: □ BG < _____ mg/dl □ BG > _____ mg/dl □ Ketones present
□ If BG is 80-100 mg/dl, give 15 grams of CHO and return to physical education, physical activity, or sports
□ May disconnect pump for sports activities
□ Student may set temporary basal rate
□ Other:

Transportation

□ BG must be > _____ mg/dl for bus ride/walk home
□ Only check BG if symptomatic prior to bus ride/walk home
□ Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia
□ Student must be transported home with parent/guardian if (specify): _____
□ Other:

Disaster Plan (if needed for lockdown, 72 hr shelter in place)

□ Continue to follow orders contained in this medical management plan
□ Additional insulin orders as follows:
□ Other:

Pump Management

Type of Pump: Pump start date: Child Lock: □ On □ Off

Basal rates: ___ unit(s)/hour ___ AM/PM ___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM ___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM ___ unit(s)/hour ___ AM/PM

Additional Hyperglycemia Management:
□ If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian
□ For infusion site failure: □ Give insulin via syringe or pen □ Change infusion site
□ For suspected pump failure, suspend or remove pump and give insulin via syringe or pen
□ If BG > ___ mg/dl and moderate to large ketones, student should change infusion site and give correction dose by pen or syringe
□ Comments:

Independent Pump Management Skills and Supervision needs*
*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate

Student is independent in the pump skills indicated below:

□ Carbohydrate counting □ Bolus an insulin dose □ Set a basal rate/temporary basal rate
□ Reconnect pump at infusion set □ Prepare and insert infusion set □ Troubleshoot alarms and malfunctions
□ Give self-injection if needed □ Disconnect pump □ Other:

Additional Orders

_____

_____

Parent/Guardian Consent for Self-Management

- I acknowledge that my child ☐ **is** ☐ **is not** authorized to self-manage as indicated by my child's health care provider.
- I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.

My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:

□ Blood glucose monitoring □ Insulin administration □ Pump management
□ Carbohydrate counting □ Insulin dose calculation □ Other:

Parent/Guardian Name:	**Signature:**	**Date:**

Provider Name:	**Signature:**	**Date:**

Acknowledged and received by:	**School Nurse:**	**Date:**